STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

July 25,1990
Letter No.:90-72

TO: All County Welfare Directors
All County Administrative Officers

SUBJECT: IMPLEMENTATION OF SAWS 1

On May 7, 1990, the Department of Social Services (DSS) issued All County Letter 90-38, which set forth AFDC and Food Stamp guidelines for the implementation of the SAWS 1 (Application for Cash Aid, Food Stamps and/or Medical Assistance), the JA 2 (Statement of Facts, Cash Aid and Food Stamps) and other forms related to the implementation of the Hunger Prevention Act. This 1988 federal act requires that DSS develop and use common application forms for persons applying for the AFDC and Food Stamp programs.

Due to the Department's time constraints in notifying counties of the impact these changes have on the Medi-Cal program, an Electronic Mail Message on this subject was sent to counties on May 21, 1990. The purpose of this letter is to provide counties with formal notification of these changes.

SAWS 1

Effective June 1, 1990, the SAWS 1 must be used for all public assistance applications, including Medi-Cal Only applications. The CA 1 shall no longer be used. The SAWS 1 incorporates an attached coversheet (called the SAWS 1 Coversheet) which provides application information regarding the three programs it serves (AFDC, Food Stamps, and Medi-Cal). A copy of the SAWS 1 is enclosed (Enclosure I). The financial information requested in Section B of the form is primarily for AFDC Immediate Need/Food Stamp Expedited Service requirements. However, Medi-Cal applicants with an immediate medical need are requested to complete questions 8, 9, and 10 to provide basic income and resource information to the county. DSS is currently conducting a further revision of the SAWS 1; therefore, we are reevaluating Section B of the form to determine whether the information it requests for Medi-Cal purposes is necessary in addition to the information obtained on the MC 210. We will notify you of the results of this reevaluation. Counties may order SAWS 1 stock from the DSS Warehouse according to the normal procedures contained in the County Forms Catalog. Counties that print their own stock may obtain a camera-ready copy of the English and Spanish-language versions of the SAWS 1 and the SAWS 1 Coversheet from Nancy Ward, DSS Forms Management Unit, (916) 322-8738 or ATSS 492-8738.

JA 2

Effective June 1, 1990, the JA 2 Statement of Facts replaces the CA 2 and shall be used only for AFDC/Food Stamp applications. It shall not be used for Medi-Cal Only applications except 1) when an AFDC/FS application is denied and the person then wishes to apply for Medi-Cal Only; or 2) as provided in Title 22, California Code of Regulations (CCR), Section 50161(e) (see Enclosure II).

SAWS 2A

The SAWS 2A form discussed in DSS All County Letter 90-38 was originally developed as a coversheet (in the form of separate document) for the SAWS 2 Statement of Facts form, which is currently intended for use only in the two SAWS counties, Napa and Merced. However, DSS has determined that the SAWS 2A shall also function as the coversheet to the JA 2, since it contains the rights and responsibilities for all three programs. Therefore, effective June 1, 1990, the SAWS 2A shall be used as a coversheet to the JA 2 for AFDC and Food Stamp applications only. The SAWS 2A shall not be used for Medi-Cal Only applications, except where an AFDC/FS application is denied and the person then wishes to apply for Medi-Cal Only. In such a case, the SAWS 2A that was signed for the AFDC/FS application will satisfy the rights/responsibilities requirement for purposes of making the eligibility determination, and the MC 216 (Rights of Persons Requesting Medi-Cal) and MC 217 (Medi-Cal Responsibilities Checklist) need not be completed until redetermination. Counties should continue to use the MC 216 and MC 217 for Medi-Cal Only applications.

If you have any questions, please call Tony Plescia at (916) 324-0650.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

COVERSHEET TO THE APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDICAL ASSISTANCE

You can apply for cash aid, food stamps, and/or full or restricted medical assistance at any time during business hours. To apply, complete Items 1-7 on the attached form, sign the Certification Section (Item 15), and give the form to the welfare office. Applicants for restricted medical assistance do not need to complete Item 1B. Before you can get aid or benefits, you must give facts during your eligibility interview. The county may also ask you to give facts on a written Statement of Facts. You must also complete all eligibility rules; the county will tell you what these rules are. If you need benefits right away, you may be able to get:

- an Aid to Families with Dependent Children (AFDC) immediate need payment within one working day
- an AFDC homeless assistance payment today
- food stamps within three days
- medical assistance as soon as you are approved. (You may need to meet your share of cost first.)

AFDC IMMEDIATE NEED

You can get an AFDC Immediate Need payment up to $100, if you appear to be eligible for cash aid AND you do not have enough income and liquid resources to pay for your needs while we work on your application. The other side of this page tells you what we mean by income and liquid resources. These needs can be for:

- Food - Clothing - Medical Care
- Rent/mortgage payments or Utility bills which are due
- Other expenses for basic needs which can't be put off

Before you can get an AFDC Immediate Need payment, complete Sections A and B, and give us all the facts we ask for during your eligibility interview. We'll tell you if you need to complete a written Statement of Facts. You may need to meet all eligibility rules, such as: giving us Social Security Numbers, registering for work, applying and accepting any income which may be available to you, cooperating with the district attorney regarding child and spousal support, etc.

AFDC HOMELESS ASSISTANCE

If you appear to be eligible for AFDC and are homeless, tell us you want to apply for homeless assistance.

FOOD STAMPS EXPEDITED SERVICE

To get food stamps within three days, your household must be eligible for the Food Stamp Program AND HAVE

- no place to live or temporary housing,

OR

- rent or mortgage and utility costs that are more than your liquid resources and this month's income before deductions (see the other side of this page for what we mean by income and liquid resources),

OR

- no more than $100 liquid resources and less than $150 income for the month before deductions,

OR

- no more than $100 liquid resources and at least one member who is a migrant or seasonal farmworker.

Before you can get food stamps within three days, complete Sections A and B and give us all the facts we ask for during your eligibility interview and give us proof of your identity. We'll tell you if you need to complete a written Statement of Facts or if we need more proof so we can give you more than one month's benefits.

MEDICAL ASSISTANCE

If you have a medical emergency or are pregnant AND want medical assistance as soon as possible, complete Sections A and Items 8, 9, and 10 in Section B. You must also give all the facts we ask for during your eligibility interview and complete all eligibility requirements. We'll tell you if you need to complete a written Statement of Facts.

TURN PAGE OVER TO GET MORE INFORMATION

WHAT WE MEAN WHEN WE SAY:

- You, Anyone, Everyone: any and all persons who live in your home and are applying for cash aid, food stamps, and/or medical assistance. When we need information about the other persons in your home, we will ask you.

- Cash Aid: AFDC (Aid to Families with Dependent Children), RDP (Refugee Demonstration Project), ECA (Entrant Cash Assistance).

- Food Stamps - benefits for low income households to help buy the food you need for good health.

- Food Stamp Expedited Service - food stamps within 3 days if you are eligible for faster service.

- Medical Assistance - Medi-Cal or any county medical coverage.

- Restricted Medical Assistance - emergency and pregnancy related care only.

  Applicants for restricted Medi-Cal don't have to give their Social Security Number, place of birth, citizen/alien status, or alien registration number.

- Disqualified - you will not get aid or benefits for a period of time.

- Income - money received or expected, such as:

  - earnings, welfare, child support, SSI or Social Security, pension or retirement payments

  - unemployment (UIB), state disability (SDI) or other disability, veterans payments

  - strike funds, payments from roomers, school grants and loans

  - cash gifts, cash winnings, any other cash payments.

- Liquid Resources - other money, such as:

  - cash on hand, uncashed checks; money in checking accounts, savings accounts; or savings certificates;

  - trust deeds, notes receivable, stocks or bonds, etc.

- Utilities: gas, electricity, heating fuel, telephone (basic rate), utility installation, garbage and trash pickup, water, sewage, etc.

OTHER THINGS YOU SHOULD KNOW:

- You can apply for cash aid and food stamps at the same time and have only one interview for both.

- You can ask for help to complete the attached form.

- If you receive too much cash aid, food stamps, or medical assistance, even if it is the county's fault, you will have to pay it back and/or your benefits may be lowered or stopped. Also, if on purpose you give wrong facts or don't report all facts or situations which affect eligibility and aid payments, you may have to pay fines and/or go to jail/prison. Food stamp recipients can also be disqualified for six months, twelve months or permanently.

- FOOD STAMPS - If you are eligible for food stamps, we will figure your benefits from the first date you apply. You can apply for food stamps the first day you contact the County Welfare Department. All you have to do the day you apply is give us your name and address (Item 1), tell us you want food stamps (Item 2), and sign the application (Item 15).

  But you still have to

  - fill out section A to apply for cash aid and medical assistance

  - fill in Item 1G and Section B if you want food stamp expedited service

  - fill out Section B if you need an AFDC Immediate Need Payment or items 8, 9 and 10 of Section B if you want medical assistance as soon as possible

  - give us all the facts we ask for during your eligibility interview and complete all eligibility requirements before you can get cash aid, food stamps, or medical assistance.

- SOCIAL SECURITY NUMBER - Federal rules say that you must give us the social security number (SSN) for each applicant for cash aid, food stamps and/or full Medi-Cal assistance. If you refuse to give us either an SSN or proof of application for an SSN, you will be disqualified from getting aid or benefits, **except applicants for restricted Medi-Cal benefits.**

  We computer match SSN(s) against records from tax, welfare, employment, the Social Security Administration and other agencies to be sure you are reporting all your income and resources. We may check out differences with employers, banks, and/or others. We also use the facts you give us to figure eligibility, benefits, and to be sure that you are not getting aid in more than one case.

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF HEALTH SERVICES

APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDICAL ASSISTANCE (SAWS 1)

Before completing this application, read the Coversheet.

SECTION A - APPLICANT INFORMATION

1A. Name of Applicant (First Middle Initial Last)

B. Social Security Number (SSN) (APPLICANTS FOR RESTRICTED MEDI-CAL BENEFITS DON'T NEED TO GIVE AN SSN) ___ ___

C. Maiden or Other Name (If Any)

D. Home Address: **Number** **Street** **City** **Zip Code**

E. Mailing Address (if different from above) **City** **Zip Code**

F. Telephone Number(s): **Home** **Work** **Message**

G. Is your home address permanent? ☐ YES ☐ NO ☐ No Home If no home, tell us where you live.

2. Is anyone applying for
Cash Aid ☐ YES ☐ NO
Food Stamps ☐ YES ☐ NO
Medical Assistance ☐ YES ☐ NO
Any Other Program(s)? ☐ YES ☐ NO
If YES, Explain:

3. Has anyone ever asked for or gotten aid anywhere: ☐ YES ☐ NO
If YES, explain: Under what name, where, when and type(s) of aid:

4. Does anyone have a personal emergency: ☐ YES ☐ NO
If YES, What Kind? ☐ Medical ☐ Pregnancy ☐ Child Abuse ☐ Spousal Abuse
☐ Elderly Abuse ☐ Other (Explain):

5. Is anyone a migrant or seasonal farmworker? ☐ YES ☐ NO
If YES, Who?

6. Is anyone pregnant? ☐ YES ☐ NO
If YES, Who?

7. The law says we must get your ethnic group and primary language. If you don't want to complete these items, the county will do it for you. This won't affect your eligibility.
a. Ethnic Group - ☐ White (not Hispanic) ☐ Hispanic ☐ Black (not Hispanic) ☐ Filipino
☐ American Indian or Alaskan Native ☐ Asian/Pacific Islander (Explain) _____
b. Language - ☐ English ☐ Chinese ☐ Lao ☐ Filipino (Tagalog) ☐ Amslan
☐ Spanish ☐ Cambodian ☐ Vietnamese ☐ Other Non-English (Explain) _____

SECTION B - COMPLETE ALL QUESTIONS FOR AFDC IMMEDIATE NEED AND/OR FOOD STAMP EXPEDITED SERVICE. COMPLETE QUESTIONS 8, 9, AND 10 IF YOU NEED MEDICAL ASSISTANCE AS SOON AS POSSIBLE.

8. How much liquid resources does everyone have?
☐ Cash, Uncashed checks or Money Orders $_____
☐ Checking/savings or credit union account(s) $_____
☐ Trust deeds, notes receivable, stocks or bonds $_____
☐ Other (Explain) $_____

9. How much income did everyone get or will get this month?
$_____ Date_____
$_____ Date_____
$_____ Date_____

10. Has your only income stopped?
☐ YES ☐ NO If YES, When?_____

11. How much is your rent or mortgage this month?
$_____ Are they due? ☐ YES ☐ NO

12. How much are your utilities that are not included in your rent this month?
$_____ Are they due? ☐ YES ☐ NO

13. Does anyone need food, clothing, medical care or other items which you can't put off?
☐ YES ☐ NO If YES, explain:

14. Do you want an AFDC Immediate Need Payment?
☐ YES ☐ NO

CERTIFICATION AND PERJURY STATEMENT

I certify that I have been given a copy of the coversheet. I understand and agree that I have to comply with eligibility rules, some of which I may be asked to do before any aid can be given. I understand that the statements I have made on this form may be checked and verified.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information I have given on this form is true, correct, and complete.

15. Signature (or Mark) of Applicant or Authorized Representative — Date Signed

Signature of Witness to Mark or Interpreter — Date Signed

COUNTY USE ONLY

COUNTY OF APPLICATION

Co of Residence (If Diff)

Date Received

Homeless

ES	AFDC HA
☐ YES	☐ YES
☐ NO	☐ NO
	☐ CA 42

☐ Referral Date:

Ethnic Group: _____
Primary Language: _____

Bills Owed $_____
Shelter costs $_____
Income/Resources $_____

Screened for ES? ☐ YES ☐ NO
Disp: IN Request: ☐ Denied/ NOA prep ☐ Approved ☐ CA approved

TYPE OF APPLICATION

CA	ES
☐ AFDC	☐ Initial
☐ RCA	☐ Recert
☐ RDP	☐ Retro
☐ ECA	

MA
☐ Full
☐ Restricted
☐ _____

☐ CWD records cleared
☐ MEDS CDB cleared
☐ IEVS initiated

Case Name

Case Number

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF HEALTH SERVICES

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C. Maiden or Other Name (If Any)

D. Home Address: Number Street City Zip Code

E. Mailing Address (If different from above) City Zip Code

F. Telephone Number(s): Home Work Message

G. Is your home address permanent? ☐ YES ☐ NO ☐ No Home If no home, tell us where you live.

2. Is anyone applying for
Cash Aid ☐ YES ☐ NO
Food Stamps ☐ YES ☐ NO
Medical Assistance ☐ YES ☐ NO
Any Other Program(s)? ☐ YES ☐ NO
If YES, Explain:

3. Has anyone ever asked for or gotten aid anywhere? ☐ YES ☐ NO
If YES, explain: Under what name, where, when and type(s) of aid:

4. Does anyone have a personal emergency ☐ YES ☐ NO
If YES, What Kind? ☐ Medical ☐ Pregnancy ☐ Child Abuse ☐ Spousal Abuse
☐ Elderly Abuse ☐ Other (Explain):

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If YES, Who?

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☐ Spanish ☐ Cambodian ☐ Vietnamese ☐ Other Non-English (Explain) ___

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$___ Date___
$___ Date___
$___ Date___

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11. How much is your rent or mortgage this month?
$___ Are they due? ☐ YES ☐ NO

12. How much are your utilities that are not included in your rent this month?
$___ Are they due? ☐ YES ☐ NO

13. Does anyone need food, clothing, medical care or other items which you can't put off?
☐ YES ☐ NO If YES, explain:

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☐ YES ☐ NO

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- I declare under penalty of perjury under the laws of the United States of America and the State of California that the information I have given on this form is true, correct, and complete.

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Signature of Witness to Mark or Interpreter — Date Signed

COUNTY USE ONLY

COUNTY OF APPLICATION

Co of Residence (If Diff)

Date Received

Homeless

	ES	AFDC HA
	☐ YES	☐ YES
	☐ NO	☐ NO
		☐ CA 42

☐ Referral Date:

Ethnic Group: ___
Primary Language: ___

Bills Owed $___
Shelter costs $___
Income/Resources $___

Screened for FS? ☐ YES ☐ NO
Disp: ☐ Approved ☐ CA approved
Disp of IN Request: ☐ Denied/NOA prep.

TYPE OF APPLICATION

CA	ES
☐ AFDC	☐ Initial
☐ RCA	☐ Recert
☐ RDP	☐ Retro
☐ ECA	

MA
☐ Full
☐ Restricted
☐ ___

☐ CWD records cleared
☐ MEDS CDB cleared
☐ IEVS initiated

Case Name

Case Number

50159. Statement of Facts. (a) Following completion of the application form, a Statement of Facts shall be completed, signed and filed with the county department.

(b) The Statement of Facts shall be used by the county department in the determination of the applicant's:

(1) Eligibility.

(2) Share of cost.

(3) Other health care coverage.

50161. Statement of Facts Form. (a) A Statement of Facts is not required in determining Medi-Cal eligibility for a child receiving aid under the Aid for Adoption of Children program.

(b) A public agency, applying on behalf of a child who may be eligible as an MI child who is not living with a parent or relative and for whom a public agency is assuming financial responsibility in whole or in part, shall complete the Application and Statement of Facts for Child in Foster Care Supported by Public Funds, MC 250.

(c) An applicant applying for Medi-Cal under any other program shall complete the Statement of Facts, form MC 210.

(d) A person applying for Medi-Cal and requesting retroactive coverage shall complete the appropriate Statement of Facts for the current month and the Supplement to Statement of Facts for Retroactive Coverage/Restoration, MC 213, for the retroactive months. If only retroactive coverage is requested, a Statement of Facts, MC 210, shall be completed for one retroactive month for which Medi-Cal is requested and the MC 213 shall be completed for each additional retroactive month.

(e) An applicant or beneficiary who has a form CA 2 which has been completed within the last 12 months and which is on file with the county department need not complete the MC 210, unless the county department determines that the applicant's or beneficiary's circumstances have changed to such a degree as to require a new Statement of Facts.